| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11968954** | **10/12/2018** |
| NAME OF PROVIDER OR SUPPLIER<br>**THE RESIDENCES OF UNITED HOMECARE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**9355 SW 158TH AVE**<br>**MIAMI, FL 33196** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

**0000 - Initial Comments**

A complaint (CCR#2018012895) survey was conducted on , 2018 and concluded 12th, 2018. The Residences of United Homecare (license #12782) had the following deficiencies identified at the time of the survey:

**0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC**

Based on observation, interview, and record review, the facility failed to keep centrally stored medications locked up at all times and failed to ensure that medications are locked in a shared . The facility also failed to ensure that expired medications were discarded for one out of 25 sampled residents (#22).

Findings included:

1) On at 5:37 AM, there was a medication cart in front of the elevator; it was not locked in front of the doors of elevators on the second floor. There were also a set of keys on top of the medication cart.

On at 5:39 AM, Staff B stated, "I'm sorry," when she was asked about the med cart being unlocked.

2) On at 8:03 AM, there were medications unsecured in . Medications were a bottle of , and , suppositories. , suppositories expired on .

Reviewed of facility's census revealed that Resident #22 occupied .

3) On at 8:03 AM, there were medication unsecured in . Medications were a bottle of Smooth tablets and a bottle of .

Reviewed of facility's census revealed that Residents #23 and #25 occupied .

Review of Resident #25's record revealed that the health assessment (AHCA form 1823) completed on . It showed that the resident needed assistance with self-administration of medications.

Class III

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
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| | **AL11968954** | **10/12/2018** |
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

**0079 - Staffing Standards - Levels - 58A-5.019(3) FAC**

Based on observation and interview, the facility did not have enough staff to arrange for resident services in accordance with the residents' scheduled and unscheduled service needs.

Findings included:

On at 5:39 AM, Staff B revealed she worked from 8 to 5 but she was covering a staff from night shift. She started the previous night at 11:00 PM. There was one certified nursing assistant (CNA) on the second floor, Staff E.

On at 5:59 AM, Staff D revealed that she changed incontinence briefs and there were 12 incontinence residents on her floor. She had to help between 13 to 14 residents during the night for changing the incontinence brief and to use the . She had about 34 residents. During night shift the staff on duties in the building can change; to floors 2, 3 or 4.

On at 6:12 AM, Staff A revealed that she worked shift 7 to 3. There was a nurse working overnight because they were short of staff.

On at 6:33 AM, Staff G revealed that she worked 11-7. She was by herself . She had more or less 37 residents and from them 10 needed help with changing incontinence brief. She changed them two to three times during the nights. She did rounds every hour. She stayed in the hallway. Residents had alarms in the and the . She stated that "order to do not give food during the night." They were not authorize to give nothing until next morning. They were supposed to be 4 staff during the night but there were days that they were 2.

On at 6:40 AM, Staff E revealed that she did rounds every two hours. There was one resident in hospice. She changed the resident's brief every time it is wet when she did the rounds.

On at 6:47 AM, Staff F revealed that there were usually 4 CNAs. She had 8 incontinence residents. She did 3 rounds during the night and changed residents if they were wet. She had one resident that was bedbound and she reposition the resident at least every two hours, and changed diaper when wet.

On at 8:12 AM, Resident #24 stated, "It is long time since I pull the alarm." She also revealed that they took good care of her but took forever to answer the alarm. On at 8:13 AM, Staff I was next to Resident #24. On at 8:13 AM, Staff I revealed that she was the only one taking

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

care of from 421 to 438 and was providing morning care. She answered as soon as she saw the call.

On at 8:55 AM confidential interview with family member revealed she observed one CNA caring for 16-18 residents. The family member was concerned about the staff to resident ratio.

Class III

**0090 - Training - - 58A-5.0191(11) FAC**

Based on record review and interview, the Assisted Living Facility failed to provide evidence of training for one of eight sampled staff within 30 days of employment, (Staff E).

Findings included:

On at 5:50 AM during tour, observed Staff E providing services to residents.

Review of Staff E's record showed a hire date of . In addition, the record showed no training for .

Exit conference on at 1:07 PM, the Administrator and office manager confirmed Staff E did not have the training.

Class III

**0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC**

Based on observation and interview, the Assisted Living facility failed to maintain the living environment for the residents.

Findings included:

On at 7:34 AM, the floor in was sticky in front of the mini-refrigerator.

On at 7:43 AM, the floor in was sticky.

On at 8:14 AM, there was light brown stain around the air conditioner unit in .

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On at 8:32 AM, the Director of Maintenance revealed that what happened on was due to condensation. They fixed the wall when that happened. They were continuously checking and fixing around the building.

Class III

**0162 - Records - Resident - 58A-5.024(3) FAC**

Based on record review and interview, the Assisted Living Facility failed to have a completed health assessment for one out of 25 sampled residents (#20). The Facility also failed to have weight recorded semi-annually for residents receiving at least assistance with the activities of daily living for one out of 25 sampled residents (#14).

Findings included:

1. Review of Resident #20's record revealed that the health assessment (AHCA form 1823) did not have the page that identified if the resident needed assistance taking her medications, list of medications and information and signature of the health care provider that completed the form.

On at 1:04 PM, Staff A revealed that was not able to find the missing page for the health assessment of Resident #20.

2. Review of Resident #14's record revealed that the health assessment (AHCA form 1823) completed on . It showed that the resident total care with the activities of daily living. Resident's weight last recorded was on and it was 128 lbs. The facility documented "unable to bear weight" on , and .

On at 1:04 PM, Staff A revealed that did not have a weight for Resident #14.

Class III

**0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC**

Based on records reviewed and interview, the facility failed failed to provide a report to the agency within 1 business day and within 15 days after the occurrence of an adverse incident for resident that had a change for two out of 25 sampled residents (#8 and #11).

Findings included:

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Review of facility's internal incident report showed that Residents #8 and #11 [illegible] that resulted in being transferred to the hospital. On [illegible] at 9:20 PM, Resident # 8 had a [illegible]. The report showed that the resident suffered a frontal bone hematoma and transferred to the hospital for medical evaluation. On [illegible], Resident #11 had a [illegible]. The incident report revealed the resident had laceration and [illegible] on the upper lip and redness on the right side of the face. Resident's daughter picked her up at 11:50 PM and took her to emergency [illegible] medical evaluation.

On [illegible] at 2:38 PM, Staff A explained that adverse incidents were not reported when a resident was transferred to the hospital unless the resident sustain a [illegible] or injury.

Class III

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
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Class III

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Class III

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Class III